Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH CARE PLLC
2821 LACKLAND RD SUITE 300
FORT WORTH TX 76116

Respondent Name
AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-13-2265-01

MFDR Date Received
MAY 6, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim for the above mentioned patient and date of service was originally filed to the patient's private BCBS and Medicare Insurance. We were unaware this was related to a Workers' Comp Injury until the patient's BCBS Insurance informed us that this was a Work Comp Injury and requested a refund on 03/08/2012. We filed the claim to the patient's Workers' Comp Insurance Gallagher Bassett on 03/21/2012, within 95 days of being notified. We received a denial dated 05/01/12 from Gallagher Bassett stating 'Time limit for filing has expired.""

Amount in Dispute: $159.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider's request was not date stamped received by DWC MRD until 5/6/13. Consequently, it is not timely as to the DOS at issue per Rule 133.307(c). The provider has failed to invoke the jurisdiction of DWC MRD as to these dates."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 4, 2011	CPT Code 97001-GP	$159.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired.
   - BL – Additional allowance is not recommended as this claim was paid in accordance with state guidelines, usual/customary policies, or the provide
   - 29 – This line was included I the reconsideration of this previously reviewed bill.

Issues

1. What is the request for medical fee dispute resolution timely submitted to the Division?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.307(c)(1)(B)(i) states, in part, that "A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. A request may be filed later than one year after the dates(s) of service if a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability." The date of service I dispute is May 4, 2011; the request for medical fee dispute resolution was received and date stamped by Medical Fee Dispute Resolution on May 6, 2013. Review of the documentation submitted by the requestor finds that none of the exceptions listed apply to this date of service.
2. Review of the documentation submitted by the requestor finds that none of the exceptions listed apply to this date of service; therefore, Medical Fee Dispute resolution does not have the authority to review this dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 23, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.